DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

FILE COPY

1. TRANSMITTAL NUMBER: 01 - 002
2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 – 447.252 and 42 CFR 447.256 – 447.299

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Pages 2 and 10 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Pages 2 and 10 (P&I)

10. SUBJECT OF AMENDMENT:
~~Revision of Disproportionate Share Calculations~~ Implements provisions of BIPA Section 702.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Bob Labbe

14. TITLE: Director, Division of Medical Assistance

15. DATE SUBMITTED:

16. RETURN TO:
Division of Medical Assistance
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR - 3

18. DATE APPROVED: JUN 29

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Terest L. TRIMBLE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

3/30

Anchorage ~~Denver~~

FORM HCFA-179 (07-92)

Instructions on Back

Family Planning Services and Supplies

For non-physician providers of family planning services, payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures without an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. Physician will be paid according to procedures described under Attachment 4.19B Page 6, Physician Services.

Federally Qualified Health Center Services

Payment for Federally Qualified Health Center services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All Federally Qualified Health Centers are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease in the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases in the scope of service furnished by the Center during that fiscal year.

Until a prospective payment methodology is established, the state will reimburse FQHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the center is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the centers for the interim period.

Home and Community-Based Waiver Services

A unit of care coordination service is reimbursed at the lesser of the amount billed the general public or the state maximum allowable for that unit of service.

A unit of specialized equipment and supplies is reimbursed at the lesser of the amount billed the general public or the state maximum allowable for that unit of service.

A unit of specialized private duty nursing service is reimbursed at the lesser of the amount billed the general public or the following state maximum allowable: registered nurse, $25 per hour; advanced nurse practitioner, $25; licensed practical nurse, $20 per hour.

A unit of environmental modifications service is reimbursed at 100 percent of billed charges up to a maximum of $10,000 per 36-month waiver period, plus an administrative fee for certain providers as approved by the managing state agency. Services must be prior authorized

The managing state agency will determine for each provider the amount of reimbursement for a unit of adult day care, chore, habilitation, meals, respite, or waiver transportation service based on the allowable direct service costs for the service provided, plus an allowance to compensate the provider for the allowable administrative and general costs associated with providing the service.

Reimbursement for a unit of residential supported living service is determined by the managing state agency based on a daily unit of service. Rates are negotiated on a per recipient per provider per waiver year basis.

Rural Health Clinic Services

Payment for Rural Health Clinic Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All Rural Health Clinic Services are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease in the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic. The clinic must supply documentation to justify scope of service adjustments.

For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar caseload, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

Until a prospective payment methodology is established, the state will reimburse RHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the visits during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

Speech, Hearing and Language Services

Payment for speech-language pathology services provided by a speech pathologist or outpatient speech therapy center is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment for hearing services provided by an audiologist is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment to a hearing aid supplier is made at the lesser of billed charges or the state maximum allowable.

Substance Abuse Rehabilitation Services

The following substance abuse rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

(a) assessment and diagnosis services;
(b) outpatient services, including individual, group, and family counseling; care coordination; and rehabilitation treatment services;
(c) intensive outpatient services;